- ❑ Initiate Waiver services
- ❑ Service Modification
  - ☐ Add a service
  - ☐ Increasing amount of service
  - ☐ Decreasing amount of service
- ❑ Provider Modification (requires 2 ISARs)
- ❑ End a service

MR Waiver Environmental Modification Individual Service Authorization Request

CSB _____

CSB provider #

_____

Provider Name:_____ Provider Number:_____

(if Medicaid provider number is assigned)

Name:	Start:	End:
Last, First MI	Date	Date

Medicaid No. _____

The individual must have at least one other MR Waiver service to receive this service.

CHECK SERVICE TO BE PROVIDED	COST	OMR USE ONLY
☐ S5165 Environmental Mod; modifications only		
☐ 99199 U4 Environmental Mod; Maintenance cost only		

Maximum Expenses = $5,000 per CSP year Note previous expenses this CSP yr: _____

Is the owner of the residence required to make reasonable accommodations according to the Americans with Disabilities Act, Virginians with Disabilities Act & the Rehabilitation Act? ☐ Yes ☐ No

Reason for this request: _____

Check the following as needed by the individual:

☐ Physical adaptation of a house or place of residence necessary to assure an individual's health & safety

☐ Physical adaptation of a house or place of residence which enable an individual to live in a non-institutional setting and to function with greater independence

☐ Modification to the individual's primary vehicle

☐ Rehabilitation Engineering (reason needed): _____

Describe the specific modifications, equipment, supplies and/or other services to be provided:

Comments:

I agree that the above plan of services is appropriate to the identified needs of this individual. This service plan has been approved by the individual and included in the CSP maintained in the Case Manager's record.

CSB Rep/ Case Manager (print) Signature Phone No. Fax No. Date